

## Money, morals and the conquest of mortality\*

J Miles Little

A RECENT EDITORIAL in the *New York Times* makes disturbing reading. It says, in part:

... the number of Americans without insurance... stood at 39 million even at the end of the booming 1990s... more than 2 million Americans lost their insurance last year.

The soaring costs are driven, in part, by the biomedical revolution of the past decade, which has produced an array of expensive new treatments for an ageing population, from drugs to fight osteoporosis to high-tech heart pumps. The result is a health care system filled with great promise and inequity — such as wonder drugs that many of the nation's elderly must struggle to afford.

Dr Janelle Walhout sees the paradox every day at the community clinic in Seattle where she works. "I've been thinking lately about the mismatch," Dr Walhout said, "between how very high-tech medicine has become, with all these genetic tests for everything, mixing your medicines like fine cocktails, and our patients, who can't afford them, can't understand it, can't get interpreters to explain it and are just not accessing those things."<sup>1</sup>

This is a newspaper editorial from the world's wealthiest country — the country that is the paradigm for development in the Western world. If the United States leads, can we be far behind?

I have been asked to speak broadly about the ethics of healthcare, as a background to a discourse of healthcare reform. There seem to be good grounds to pursue reform; and yet there's been so much that is good that has happened in the last 50 years. To take but one example, cancer survival overall has risen from 30% to 50%. Some malignancies, such as Hodgkin's disease and some kinds of testicular cancer, are curable, even when they're quite advanced. Prevention and early detection have changed the whole history of malignant melanoma, that most Australian of cancers. The genetic basis of a few cancers has been determined, and that may lead to preventive or even curative approaches. However, there is an obdurate residue that we

cannot shift. Advanced bowel cancer is common and generally unresponsive. Lung cancer still has a poor outlook. We will all die of something, and strokes, heart disease and cancer remain the three most common causes. These are the sad facts that govern our lives, but my concern here is to talk about the social and political systems in which healthcare is embedded, and why progress in science and technology masks deep social and ethical problems.

My view of the future for Western health and medicine is bleak. The gaps between rich and poor, between their health, wealth, welfare, access to justice, education and pleasure, will widen. The burgeoning technology that promises so much will prove to be of inestimable benefit to those who can afford it, and who, in many ways, need it least. Commercial interests will prevail increasingly over moral commitments, and multinational companies will continue their course to replace nation states as the centres of political and economic power. Global issues, such as pollution, environmental destruction and global warming, will be endlessly discussed, and endlessly dismissed. Spiritual and aesthetic issues will decline in importance still further, and money will become almost the sole criterion of worth. Universities, healthcare systems, churches and cults will be judged, and will appraise themselves, by their capacity to make profits rather than prophets. All these things will happen in Australia and in most of the Western world. Indeed, this pattern of development is seen to be the criterion of successful development. Those countries that can't make it in such an environment will be marginalised, and seen as "opportunities for investment" or as "sources of cheap labour".

These things are happening now, and I see nothing that is likely to change this progression. At its root are two closely linked things — the science of economics (if it *is* a science) and the colonisation of values by money.<sup>2,3</sup> Economics defines itself as the branch of knowledge that deals with the distribution of wealth on one hand, and (in its more idealistic moments) as "the study of how men [*sic*] and society end up choosing, with or without the use of money, to employ scarce productive resources... It analyses the costs and benefits of improving patterns of resource allocation".<sup>4</sup>

Unfortunately, these definitions represent conflicting priorities. The distribution of wealth ties economics to money, to a utilitarian calculus, and to commercial values. The domain of scarce resources is communitarian and socially oriented. The *dominant* paradigm, however, is that of handling wealth and managing the monetary economy, a "neo-classical" model. It is economists of this persuasion who advise and influence heads of state, who determine whether interest rates will inflict "necessary pain" in order to adjust the national inflation figures or "limit the blow-out in the balance of trade".

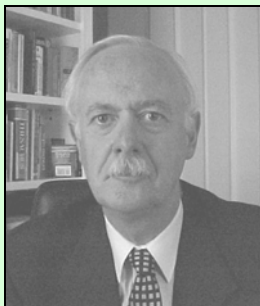
\* A keynote address presented at the Australian Health Care Summit 2003.

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There are, of course, economists of the communitarian or socially conscious persuasion,<sup>5-8</sup> but they work for social change at the margins of both mainstream politics and mainstream economics. They have their apparent victories, as John Deeble did with Medicare in Australia. However, at the end of the day, some form of “economic rationalism” dominates, because it is money management that influences politicians.

And it is money that is the problem. Money presumably began life as a convenience, as a portable means of trading that put an exchange medium in the place of barter. It began life as a symbol of value, but has become an abstraction against which value is measured. Money thus colonises our moral space.

It has also colonised political space almost completely. In Australia, for example, there’s effectively only one viable political party. We might call it the Economic Realist Party. Like the recognised parties, it has its factions. Just to the left of centre is a faction which insists on emphasising a (heavily qualified) social awareness. To the right, a counterfaction espouses a (qualified) free-market philosophy. Both factions woo the corporate sector; both make gestures toward social welfare. Both temper their ideals with appeals to the central reality of economic restraints.

Inevitably, this determines policy for all public services, whether they be in education, transport, housing, roads, defence or health. Levels of services are determined by what we can afford rather than what we can transact between each other. It’s scarcely realistic to suggest going back to some kind of barter system in any westernised country — although Argentina’s recent social credit experiment suggests that the idea isn’t dead — but we do need to understand how money alienates us from the sustaining, foundational values which underlie the provision of any services.

The effective colonisation of morals and politics by money and commerce has far-reaching consequences. Commercial values and the notion of the legally binding contract have replaced *trust* in many relationships, including those between patients and their families, and doctors. The ideal of *service* has been replaced by the legally nuanced “duty of care”. Our adversarial legal system has entered the space of health services more and more intrusively, so that “defensive medicine” is now an established (and very expensive) part of healthcare practice.<sup>9,10</sup> The costs of healthcare services have inevitably demanded that commercial and economic ideas, such as “best practice”, “efficiency”, “cost-effectiveness”, “outcomes”, and “evidence-based medicine” have become more important than human relationships and the nature of the processes of healthcare. Compassion and time to talk return no dollars that can be easily identified on a balance sheet, yet they’re as fundamentally important in healthcare as any technology.

Healthcare services are essentially moral endeavours. Western governments and other agencies are obliged to provide them because people generally value human life in both quantity and quality.<sup>11</sup> Each person wants to be protected from illness, and, when illness strikes, to be looked after. Each wants some sort of bulwark against the

risks and sufferings that illness threatens. *This is the value that underpins the ethics of healthcare.* If we didn’t value human life to a significant extent, societies wouldn’t permit the expenditure that governments put into healthcare services. Huge amounts of money are committed. Individuals and corporations can become immensely wealthy by supplying goods and services within the healthcare sector. Science and technology continually promise more and better ways to diagnose and cure disease. Life expectancy in Australia was 78.2 years in 1997.<sup>12</sup> It has increased by more than 20 years in the US in the last 100 years.<sup>13</sup> The last gains have been the hardest and the most expensive, and that’s a common pattern of technological advance.<sup>14</sup>

It’s time to recognise that we are in the phase of diminishing returns,<sup>13</sup> and to re-examine what more we *can* achieve. Although we are told by some that economics is the science of distributing scarce resources, it’s not really the resources which are scarce in themselves. It’s the scarcity of money that is the problem. If there were more money, we could train and employ any number of doctors, buy computed tomography scanners for every town, and have oncology services and palliative care distributed widely. We could provide sophisticated services for outback towns, public health programs for Indigenous communities, and we could endlessly fund molecular and genetic research in cancer. Whether this increased expenditure would translate into better public health is another question. It would probably make little difference. The public health parameters for Australia, the United Kingdom and the US are very similar, despite differences in expenditure from more than 14% of gross domestic product in the US to about 7% in the UK.<sup>12</sup>

Speaking ethically, it’s quite likely we could achieve greater health gains by concentrating on improving the health of those with the greatest health needs — the poor, the elderly, the unemployed, Indigenous groups — but it is far *more* likely that medical research will continue to be funded for the advancement of “high-end” technology, such as molecular genetics and gene therapy. These technological wonders *may* produce some benefits, but it is extremely unlikely that they will produce the revolutions confidently predicted by scientists at the start of the Human Genome Project. Further, we must ask ourselves who might reap those benefits — the already wealthy (and statistically more healthy), or the poor and needy? As the medical technology corporations inevitably think in terms of profit rather than public service or morality, each advance will come at a price that will be beyond the reach of the disadvantaged, and beyond the reach of most governments to subsidise.

Healthcare, then, is underpinned by two imperatives — the relief of suffering and the prevention of death.

The massive expenditure of effort and money that Western societies commit to prolonging life has become a defining characteristic of our culture and our times. We fear death, and no amount of stoical rationality can remove that intuitive fear.<sup>15,16</sup> When our lives are threatened, we struggle to survive. It’s not surprising, therefore, that our community wants access to healthcare that defends us and our loved ones against the reality and inevitability of death. Medical technology, health systems, medical research — all are

sustained and justified, in major part, by our intuitive desire to oppose death and dying with systems that ensure our security and hold out hopes for our flourishing.

This is all perfectly good and appropriate — up to a point, but there are some awkward consequences, and we are already in the midst of some of them:

■ It seems unlikely that death can ever be entirely eliminated. That means that, somewhere along the line, we'll all have to accept that there is a stopping point, a point at which we *must* call a halt. There is an old law of technological development that says that the last gains are the hardest.<sup>14</sup> In other words, we *must* enter a phase of diminishing returns, waiting for a paradigm shift that moves us away from the established models. In watchmaking, for example, the invention of the quartz movement suddenly made accuracy cheap. No such paradigm shift is on the horizon for medicine. The genetic revolution is immensely expensive, and genetic interventions — exciting though they promise to be — are not likely to be available at bargain prices nor free of patents. Further prolongation of life, beyond, say, an average of 80 years or so, will be increasingly costly.

■ In a global context, the endless prolongation of average life-span is irrelevant. Most of the world's populations live in what the Western world defines as poverty, with health statistics that are unthinkable in "advanced" countries. Even within wealthy nations — like Australia — there are subpopulations of the Indigenous, the poor, the handicapped, whose health is poor and whose deaths occur at significantly younger ages. World health, in which we are all involved whether we like it or not, doesn't depend on cutting-edge technological advances, but on moral awareness and political commitment.

■ The indefinite prolongation of life raises practical and moral issues of great complexity and profound significance. Say that scientists find ways to prolong average life span to 100 years. In Western cultures, the 80 years of average life causes problems enough. We've scarcely *begun* to manage the problems of the ageing population. We lack facilities, personnel and funds to care for the aged. Those same scientists will have to find ways to reduce the impact of ageing, so that less care is needed for the elderly. And then, should they succeed in that endeavour, they create another problem. Fit, mentally active people aged 70–80 years will need some way to occupy their time, not just playing bingo or lawn bowls, but working and using their skills and their great experience. How will we achieve this while remaining fair towards younger people wanting to secure and advance their own careers? And how will we manage the population pressures? If the mean duration of life increases, populations will increase, unless birth rates fall even further. And what will a further fall in birth rate do to the balance of ages within our community, to the rights of younger people, to their capacity to earn?

Medical research is a wonderful thing, and it does much to increase the sense of security we all feel in our societies, but perhaps it addresses too much the ambition of endless prolongation of life. Perhaps it should turn more to an understanding of suffering,<sup>17</sup> to ways of making the *average* life-span more enjoyable, more secure. Maybe we should do

more qualitative research, which is relatively cheap to fund and produces insights that can help healthcare deliverers, educators and policy makers. In our knowledgeable, paternalistic way, we seem to be always prescribing "appropriate" or "sustainable" technology for the Third World. Perhaps we need to listen to our own advice, to curb our ambitions for immortality. Perhaps we need to decide, as a community, how much we're *prepared* to spend on healthcare and medicine, and then determine — as they did in the state of Oregon in the US<sup>18,19</sup> — just what priorities consumers want. We need, in other words, to decide what it is appropriate for *us* to do. Community consultation is a part of Danish life. We've even done it in Australia at the Constitutional Convention and the Community Jury on Genetically Modified Food. Recently, Gabbay and colleagues in Southampton described the formation and successful function of facilitated groups called Communities of Practice, which assemble stakeholders to examine available evidence and formulate policy suggestions.<sup>20</sup> It is not impossible to consult communities, and it sometime produces results that surprise us all.

Medical research and the advance of technology will continue, as indeed they should, but we must stop seeing research and technology as ends in themselves, or as directed solely toward the conquest of death. Healthcare is justified just as much by its capacity to limit suffering. If the thrilling advances of cutting-edge science are available only to the few who can afford them, we face some real moral dilemmas. They're dilemmas which should prompt us to think about the values we might want for ourselves and our children. There *are* limits to growth, and limits to what we *can* afford.

Here, then, is the message from ethics; a call for action rather than an appeal to theory. It's time to look at the society in which we live, and to ask ourselves "Is this a society in which there's real justice? Is this a society where I and my loved ones, in our time of trouble, can be sure to access care which is compassionate, thoughtful and appropriate?" I don't know what conclusions you'll reach in this Summit, but I do know that you'll have wasted your time, and failed the constituency of the ill, if you fail to think deeply about these questions, and to suggest plans of action which will let us answer "yes" to both.

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